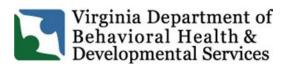


## **Referral for Dental Services**

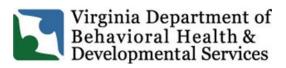
This form must be filled out completely and submitted by the Individual's CSB Representative. Incomplete forms will be returned to the CSB Representative. Return this form to <a href="mailto:DentalTeam@dbhds.virginia.gov">DentalTeam@dbhds.virginia.gov</a>. Forms will ONLY be accepted by email unless prior arrangements have been made with Dental Management.

Date of Request:	Date of Birth:		
Individual's Name:	Preferred Name:		
☐ This individual has an intellectual or development	·		
Level of Intellectual/Developmental Disability:	□ Profound □ Severe □ Moderate □ Mind		
☐ This individual is in need of Dental Care			
Date of their last dental visit:	visit. This field cannot be left blank or listed as "Unknown."		
Does the individual have Medicaid? ☐ Yes ☐ No			
If yes, what Managed Care Organization (MCO) have they selected?			
☐ Aetna ☐ Anthem ☐ Magellan ☐ Optima ☐ United Healthcare ☐ Virginia Premier ☐ None			
Does the individual require any type of sedation for their	r dental visits?		
Is this individual a previous resident or previously received services at any Virginia Training Center? $\square$ Yes $\square$ No If yes, what Virginia Training Center?			
☐ CVTC ☐ NVTC ☐ SEVTC ☐ SVTC/Hiram ☐ SWVTC			
Community Service Board:			
Community Service Board Representative:			
Phone Number:	Email:		
CSB Representative Signature:	Date:		
FOR OFFICE USE ONLY			
□ Region 1 □ Region 2 □ Region 3 □ Region 4 □ Region 5			



## **CLIENT INFORMATION**

Indicate individual's type of residence:	☐ Family Home ☐	☐ Group Home ☐ ICF
Name of Group Home/ICF (if applicable	e):	
Street Address:		Apt/Suite:
City/Town:		Zip Code:
Is the individual his or her own legal g	guardian? ☐ Yes ☐ No	
Legal Guardian/Authorized Represent	tative (if applicable):	
Phone:	Email:	
Residential Care Provider (if different fr	rom Legal Guardian):	
Phone:	Email:	
Emergency Contact:		Relationship:
Phone:	Email:	
	<u> </u>	
П	OAY SUPPORT INFORMA	ATION
Does the individual attend a Day Progr	am? □ Yes □ No	
Day Program Name:		
Street Address:		
City/Town:		Zip Code:
Days and Hours of Attendance:		



## MEDICAL INFORMATION

Medical Diagnosis:	
Prescribed Medications:	
Allergies (please describe reaction):	



## **CAPABILITIES**

Is the individual ambulatory? $\square$ Yes $\square$ No		
If no, does the individual use one of the following?		
□ Power Wheelchair □ Manual Wheelchair □ Walker □ Bed ridden □ Other		
Wheelchair Width from wheel to wheel:		
How does the individual communicate?		
□ Non-verbal □ Verbal □ Gestures □ Manual Signing □ Vocalizations		
☐ Other Communicative Devices		
Does the individual have any sensory impairments?		
☐ Deaf ☐ Partially Deaf ☐ Blind ☐ Partially Blind		
Does the individual require staff assistance?		
□ Total Staff Assistance □ Mostly Staff Assistance □ Minimal Staff Assistance □ Independent		
Additional Patient Considerations (include likes, dislikes, previous experiences, concerns):		
FOR OFFICE USE ONLY		
This individual's referral to the DBHDS Dental Program has been: ☐ Approved ☐ Denied		
Referred To:		
Phone Number to schedule appointment:		
Address:		
City/State:		
Approved by:		